

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-000084

STATE FILE NUMBER

AMENDED

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 17

FILED JAN 30 1962

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Audrain</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Montgomery</u>               |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Mexico</u>  |   | c. CITY OR TOWN <u>Wellsville</u>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Audrain Hospital</u>  |   | d. STREET ADDRESS (If outside, give location)<br><u>512 Continental</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Walker</u> Middle <u>Dyer</u> Last <u>Jones</u>  |   | 4. DATE OF DEATH<br>Month <u>Jan.</u> Day <u>20</u> Year <u>1962</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>white</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept 12, 1879</u>                       |
| 9. AGE (last birthday)<br><u>82</u>   |   | 10. IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>8</u> Hours <u></u> Min. <u></u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>retired truck driver</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>R.E.A.</u>  |  |
| 11. BIRTHPLACE (City and state or country)<br><u>Callaway Co. Mo.</u>   |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |  |
| 13a. FATHER'S NAME<br><u>Nuton Jones</u>  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Kate Dyer</u>   |  |
| 14. NAME OF HUSBAND OR WIFE<br><u>Martha Brooks Jones</u>   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>                                    |  |
| 16. SOCIAL SECURITY NO.<br><u></u>  |   | 17. INFORMANT<br>Address<br><u>Mrs. Martha Jones, Wellsville.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial failure</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>myocardial scarring</u><br>DUE TO (c) <u>coronary arteriosclerosis</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days</u><br><u>3 months</u><br><u>2 years</u>   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Hour <u></u> a.m. <u></u> p.m. <u></u>   | Month, Day, Year <u></u>  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 20f. CITY, TOWN, OR LOCATION  | COUNTY <u></u> STATE <u></u>                                   |
| 21. I attended the deceased from <u>10-22-61</u> to <u>1-20-62</u> and last saw <u>her</u> alive on <u>1-20-62</u><br>Death occurred at <u>2:10</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.   |   |   |  |
| 22a. SIGNATURE<br><u>Howard F. Myers</u>  |   | 22b. ADDRESS<br><u>Wellsville Mo</u>  |  |
| 22c. DATE SIGNED<br><u>1-22-62</u>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE<br><u>Jan. 22, 1962</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Wellsville</u>   | 23d. LOCATION (City, town, or county)<br><u>Wellsville, MO</u> |
| 24. FUNERAL DIRECTOR<br><u>Howard F. Myers</u>  |   | 25. DATE RECD. BY LOCAL REG.<br><u>January 22-1962</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Blanche Neely</u>              |

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 30 1962

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Howard T. Myers*

Licensed Embalmer No. 4494

P. O. Address Walleraville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.